SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

**VOLUNTARY CHILD SUPPORT/CONTRIBUTIONS FORM**

| | |
|---|---|
| **To:** _____ | **Name of Applicant/Beneficiary:** |
| **Address:** _____ | **Address of Applicant/Beneficiary:** |
| _____ | **Budget Group Number:** |

**THE ABOVE-NAMED APPLICANT/BENEFICIARY HAS REPORTED THAT (S)HE RECEIVED CASH CONTRIBUTIONS OR CHILD SUPPORT FROM YOU. PLEASE COMPLETE THE ITEMS CHECKED BELOW AND RETURN THIS FORM TO:**
**_____DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**ADDRESS:** _____

**MEDICAID ELIGIBILITY WORKER'S NAME:** _____ **DATE:** _____

**I. CONTRIBUTIONS**

☐ **1. Do you give any money directly to**_____ **? ☐Yes☐No**

☐ **2. For what purpose is the money given?** _____

☐ **3. How much did you give? Month** _____ **Amount**_____ **Month** _____ **Amount** _____

**Month** _____ **Amount** _____ **Month** _____ **Amount** _____

☐ **4. Is this money a gift?☐ Yes ☐No Is this money a loan? ☐Yes ☐No**

☐ **5. If a loan, when do you expect to be repaid?**

**II. CHILD SUPPORT**

☐ **1. Are you the parent of** _____**? ☐Yes☐No**

☐ **2. Are you giving any money for support of** _____**? ☐Yes☐No**

**If yes, how much and how often?** _____

☐ **3. Are you giving support money on a regular basis?☐Yes☐No**

☐ **4. How long have you been giving support money?** _____

☐ **5. How do you pay this money? (Check One) ☐By Cash ☐By Check ☐ Other** _____

☐ **6. To whom do you pay this money? (Check One) ☐a. Applicant/Beneficiary ☐b. Clerk of Court**

☐ **c. Department of Social Services ☐ d. Other Who?** _____

☐ **7. How much did you give?**

**Month**_____ **Amount**_____

**Month**_____ **Amount**_____

**Month**_____ **Amount**_____

**DO YOU HAVE ANY PROOF OF PAYMENT, SUCH AS RECEIPTS OR CANCELLED CHECKS?**
**☐Yes ☐No**
**IF SO, PLEASE ENCLOSE THEM. THEY WILL BE COPIED AND RETURNED TO YOU PROMPTLY**

☐ **8. Do you have medical/hospital insurance on** _____**? ☐Yes☐No**

**If yes, tell us the company's name** _____

☐ **9. Do you have a Driver's License? ☐ Yes ☐ No If yes, print your DL number** _____

☐ **10. What is your Social Security Number?** _____**; Date of Birth:** _____

☐ **11. Where do you work? Name of Company:** _____

**Company's Address:** _____

**Company's Telephone No.:** _____

| **Your Signature:** | **Your Telephone Number:** | **Date:** |
|---|---|---|
| | | |

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

## Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

## Language Services

**If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).**

**si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).**

**أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:**

**888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)**

**Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).**

**Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).**

**Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).**

**Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)**

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

**Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.**

**धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।**

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

**Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.**

**Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).**

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။